HUDSON VALLEY CENTER FOR COGNITIVE THERAPY
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# AUTHORIZATION FOR RELEASE OF INFORMATION

This form authorizes your therapist to release protected information to the person/facility/agency you designate.

I authorize my therapist at the HVCCT to request and release verbal and written assessment and treatment information to:

_____
Name and Contact Information

I am requesting my therapist to release and/or receive this information for the following reason:

_____ Facilitation/Coordination of assessment and treatment

_____ Other (please specify) _____

I understand that I have the right to revoke this authorization on writing at any time. The revocation will not apply to any information that has already been released in response to this authorization. This authorization will in expire one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information. I also understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have the right to receive a copy of this authorization upon my request. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the information may not be protected by the federal privacy rules or by New York law.

**By typing your name below, you are signing this consent form electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form.**

_____
Printed Name of Patient

_____
Signature of Patient (If patient resides in NJ, minors 14+ must sign)

_____
Signature of Parent or Guardian

_____
Date

_____
HVCCT Therapist Releasing Information